AMENDED IN SENATE SEPTEMBER 7, 1999

AMENDED IN SENATE AUGUST 24, 1999

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AMENDED IN SENATE JULY 1, 1999

AMENDED IN ASSEMBLY MAY 25, 1999

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL No. 12

Introduced by Assembly Member Davis
(Coauthor: Assembly Member Correa)

December 7, 1998

An act to add Section 1383.15 to the Health and Safety Code, and to add Section 10123.68 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 12, as amended, Davis. Health care coverage: second opinions.

Under existing law, the Knox-Keene Health Care Service Plan Act of 1975, health care service plans are regulated by the Commissioner of Corporations. Existing law provides that disability insurers are regulated by the Insurance Commissioner. Willful violation of the law regulating health care service plans is a crime.

Existing law requires health care service plans and certain disability insurers to file a written policy describing the

manner in which the plans or insurers determine if a 2nd medical opinion is medically necessary and appropriate.

This bill would require a health care service plan and certain disability insurers to provide or authorize a ~~medically necessary or appropriate~~ 2nd opinion by an appropriately qualified health care professional if requested by an enrollee or an insured, or a participating or contracting health professional who is treating an enrollee or insured. The bill would also specify reasons for a 2nd opinion to be provided or authorized if, among other things, any one of 5 specified conditions occurs. The bill would also specify the mechanism for obtaining a 2nd opinion and the eligible providers for rendering a 2nd opinion.

This bill would also require an authorization or denial to be provided in an expeditious manner *and would prescribe the conditions under which a second opinion must be rendered within 72 hours*, would require that the plan or insurer file timelines for responding to requests for 2nd opinions, as described, by July 1, 2000, with the appropriate state agency, and would require that the timelines be made available to the public upon request. This bill would not apply to health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements and that do not limit 2nd medical opinions, to disability insurers that do not limit 2nd medical opinions, or to certain other specialized types of health insurance.

By changing the definition of a crime regarding health care service plans, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1383.15 is added to the Health and Safety Code, immediately following Section 1383.1, to read:

1383.15. (a) When requested by an enrollee or participating health professional who is treating an enrollee, a health care service plan shall provide or authorize a ~~medically necessary or appropriate~~ second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

(1) If the enrollee questions the reasonableness or necessity of recommended surgical procedures.

(2) If the enrollee questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

(3) If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the enrollee requests an additional diagnosis.

(4) If the treatment plan in progress is not improving the medical condition of the enrollee within an appropriate period of time given the diagnosis and plan of care, and the enrollee requests a second opinion regarding the diagnosis or continuance of the treatment.

(5) If the enrollee has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

(b) For purposes of this section, an appropriately qualified health care professional is a *primary care physician or a* specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

(c) If an enrollee or participating health professional who is treating an enrollee requests a second opinion pursuant to this section, an authorization or denial shall be provided in an expeditious manner. *When the enrollee's condition is such that the enrollee faces an imminent and serious threat ot his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the enrollee's ability to regain maximum function, the second opinion shall be rendered in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the request, whenever possible.* Each plan shall file with the Department of ~~Corporations~~ *Managed Care* timelines for responding to requests for second opinions for cases involving emergency needs, urgent care, and other requests by July 1, 2000, and within 30 days of any amendment to the timelines. The timelines shall be made available to the public upon request.

(d) If a health care service plan approves a request by an enrollee for a second opinion, the enrollee shall be responsible only for the costs of applicable copayments that the plan requires for similar referrals.

(e) If the enrollee is requesting a second opinion about care from his or her primary care physician, the second opinion shall be provided by an appropriately qualified health care professional *of the enrollee's choice* within the same physician organization.

(f) If the enrollee is requesting a second opinion about care from a specialist, the second opinion shall be provided by any ~~contracted plan provider of the same~~ *provider of the enrollee's choice from any independent practice association or medical group within the network of the same or equivalent* specialty. If the specialist is not within the same physician organization, the plan shall incur the cost or negotiate the fee arrangements of that second opinion, beyond the applicable copayments which shall be paid by the enrollee. ~~Additional second~~ *If not authorized by the plan, additional medical* opinions

not within the original physician organization shall be the responsibility of the enrollee.

~~(g) The enrollee shall obtain services only from a provider who is participating in, or under contract with, the plan pursuant to the specific contract between the plan and the subscriber. The plan may limit referrals to its network of providers if there is a participating plan provider who meets the standard specified in subdivision (b).~~

(g) If there is no participating plan provider *within the network* who meets ~~this standard,~~ *the standard specified in subdivision (b),* then the plan shall authorize a second opinion by an appropriately qualified health professional outside of the plan's provider network. In approving ~~a referral for~~ a second opinion either inside or outside of the plan's provider network, the plan shall take into account the ability of the enrollee to travel to the provider.

(h) The health care service plan shall require the second opinion health professional to provide the enrollee and the initial health professional with a consultation report, including any recommended procedures or tests that the second opinion health professional believes appropriate. Nothing in this section shall be construed to prevent the plan from authorizing, based on its independent determination, additional medical opinions concerning the medical condition of an enrollee.

(i) If the health care service plan denies a request by an enrollee for a second opinion, it shall notify the enrollee in writing of the reasons for the denial and shall inform the enrollee of the right to file a grievance with the plan. The notice shall comply with subdivision (b) of Section 1368.02.

(j) *Unless authorized by the plan, in order for services to be covered the enrollee shall obtain services only from a provider who is participating in, or under contract with, the plan pursuant to the specific contract under which the enrollee is entitled to health care services. The plan may limit referrals to its network of providers if there is*

a participating plan provider who meets the standard specified in subdivision (b).

(k) This section shall not apply to health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements if, subject to all other terms and conditions of the contract that apply generally to all other benefits, access to and coverage for second opinions are not limited.

SEC. 2. Section 10123.68 is added to the Insurance Code, immediately following Section 10123.67, to read:

10123.68. (a) When requested by an insured or contracting health professional who is treating an insured, a disability insurer that covers hospital, medical, or surgical expenses shall authorize a ~~medically necessary or appropriate~~ second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

(1) If the insured questions the reasonableness or necessity of recommended surgical procedures.

(2) If the insured questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

(3) If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the insured requests an additional diagnosis.

(4) If the treatment plan in progress is not improving the medical condition of the insured within an appropriate period of time given the diagnosis and plan of care, and the insured requests a second opinion regarding the diagnosis or continuance of the treatment.

(5) If the insured has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

(b) For purposes of this section, an appropriately qualified health care professional is a *primary care physician or a* specialist who is acting within his or her

scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

(c) If an insured or participating health professional who is treating an insured requests a second opinion pursuant to this section, an authorization or denial shall be provided in an expeditious manner. *When the insured's condition is such that the insured faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the insured's life or health or could jeopardize the insured's ability to regain maximum function, the second opinion shall be rendered in a timely fashion appropriate to the nature of the insured's condition, no to exceed 72 hours after the insurer's receipt of the request, whenever possible.* Each insurer shall file with the Department of Insurance timelines for responding to requests for second opinions for cases involving emergency needs, urgent care, and other requests by July 1, 2000, and within 30 days of any amendment to the timelines. The timelines shall be made available to the public upon request.

(d) If an insurer approves a request by an insured for a second opinion, the insured shall be responsible only for the costs of applicable ~~coinsurances~~ *copayments* that the insurer requires for similar referrals.

(e) If the insured is requesting a second opinion about care from his or her primary care physician, the second opinion shall be provided by an appropriately qualified health care professional *of the insured's choice* who is contracted with the insurer.

(f) If the insured is requesting a second opinion about care from a specialist, the second opinion shall be provided by any ~~contracted provider of the same specialty.~~ *provider of the same or equivalent specialty, of the insured's choice, within the insurer's provider network, if the insurance contract limits second opinions to within a network.*

~~(g) The insured shall obtain services only from a provider who is participating in, or under contract with, the insurer pursuant to the specific contract between the insurer and the insured. The insurer may limit referrals to its network of providers if there is a participating~~

(g) The insurer may limit second opinions to its network of providers if the insurance contract limits the benefit to within a network of providers and there is a participating provider who meets the standard specified in subdivision (b). If there is no participating provider who meets this standard, then the insurer shall authorize a second opinion by an appropriately qualified health professional outside of the insurer's provider network. In approving a~~ referral for a~~ second opinion either inside or outside of the insurer's provider network, the insurer shall take into account the ability of the insured to travel to the provider.

(h) The insurer shall require the second opinion health professional to provide the insured and the initial health professional with a consultation report, including any recommended procedures or tests that the second opinion health professional believes appropriate. Nothing in this section shall be construed to prevent the insurer from authorizing, based on its independent determination, additional medical opinions concerning the medical condition of an insured.

(i) If the insurer denies a request by an insured for a second opinion, it shall notify the insured in writing of the reasons for the denial and shall inform the insured of the right to dispute the ~~claim~~ *denial, and the procedures for exercising that right.*

(j) *If the insurance contract limits health care services to within a network of providers, in order for coverage to be in force, the insured shall obtain services only from a provider who is participating in, or under contract with, the insurer pursuant to the specific insurance contract under which the insured is entitled to health care service benefits.*

(k) This section shall not apply to any policy or contract of disability insurance that covers hospital,

medical, or surgical expenses and that does not limit second opinions, subject to all other terms and conditions of the contract.

~~(k)~~

(l) This section shall not apply to accident-only, specified disease, *or* hospital indemnity~~, or long-term care~~ health insurance policies.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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